



# NATIONAL HEALTH POLICY



MINISTRY OF HEALTH, ERITREA

THE STATE OF ERITREA MINISTRY OF HEALTH

March 2010



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## FORWARD

Although the Eritrean health system has enormously grown since independence in 1991, it has become necessary to review our policies and strategies to allow consolidation and future sustainability. After independence, the government was faced with the challenge of poor health status of the population, attributable to war-related devastation of essential infrastructures and services. The severity of the problem was evident from high morbidity and mortality rates due to preventable causes, especially among children and women.

The government's priority in the past phase of development since independence therefore, was development of skilled human resource for health, reconstruction of the health infrastructure, instituting health systems and intensive PHC based programme interventions for communicable diseases. The long protracted war provided health workers a deep understanding of what the country needed in terms of health care services which formed the basis for a rapid response and systematic establishment of a health system.

By means of this policy the health sector will contribute to the aspiration of the Health Sector Strategic Development Plan 2010-2014 "for developing a dynamic economy and better quality of life of all citizens" and subsequent other development plans.

In order to attain the overall national development goals of the government, the health sector will strengthen community based health services, gradually restructure facility-based health services in order to make them more responsive to the people closest to their homes especially in the rural areas, strengthen decentralised health governance structures, improve efficiency and the quality of care provided by hospitals and strengthen health sector coordination at all levels to enable better participation of all players, whether public or private.

It is my sincere hope that all health workers, development partners and other players in the health sector will endeavour to institute necessary measures to facilitate implementation of this policy.

I express my appreciation to all those who worked hard and to all those who contributed technically or financially to produce this National Health Policy. I would also like to urge the whole manpower of the health sector and all stake holders to work harder to put the policy into action.

Amina Nurhusein  
Minister for Health

## LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
BCC	Behaviour change communication
BHCP	Basic Health Care Package
CHA	Community Health Agent
DKB	Dehubawi Keyh Bahri zone
DOTs	Directly Observed Treatment Strategy
EDHS	Eritrea Demographic and Health Survey
EHP	Eritrea Health Package
FGM	Female Genital Mutilation
FP	Family Planning
GB	Gash Barka zone
GDP	Gross Domestic Product
GOE	Government of Eritrea
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resource for Health
HSSDP	Health Sector Strategic and Development Plan
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant mortality rate
ITNs	Insecticide Treated Nets
IVM	Integrated Vector Management
LLINs	Long lasting Insecticide Treated Nets
MA	Maakel zone
MDR-TB	Multidrug-Resistant Tuberculosis
MMR	Maternal mortality rate
MND	Ministry of National Development
MOH	Ministry of Health
NCDs	Non-communicable diseases
NDP	National Drug Policy
NHP	National Health Policy
NRH	National Referral Hospitals
ODA	Official Development Aid
PHC	Primary Health Care
PLHAs	People living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
RHS	Reproductive Health Services
SKB	Semenawi Kehy Bahri
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
SZHMT	Sub-Zobal Health Management Team
TB	Tuberculosis
U5MR	Under-five mortality rate
VHC	Village Health Committee
WHO	World Health Organisation
ZHMT	Zoba Health Management Team
ZMO	Zobal Medical Officer

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## Executive Summary

The State of Eritrea post-independence has focused on development of health professionals, constructing/rehabilitating health facilities, PHC interventions to address key health challenges with an aim of controlling malaria, reducing the HIV/AIDS burden, maternal and child mortality, etc with significant results. This necessitated an increased acquisition of inputs such as additional re-oriented human resources for health, pharmaceutical and other supplies, physical infrastructure and medical equipment with a special emphasis on the regions that were most in need.

Notwithstanding the improved access to health services, there still remain challenges such as the low (around one third) pregnant women who are delivered deliveries by skilled attendants; high neonatal mortality;; TB prevalence and incidence is still a challenge; possible threat of resurgence of malaria due to cross border transmission and emergence and/or re-emergence of vector-borne diseases due partly to irrigation expansion for food security. Other sector challenges are an increasing prevalence of non-communicable diseases and injuries; double burden of communicable and non-communicable diseases and progressive technological advancement in health, has led to a high demand for appropriately skilled health personnel; supply of funding that is outstripped by current and potential demands.

In response to these challenges in the coming decades, the health sector will strive to attain the following strategic policy goals:

1. Significantly reduce the burden of early childhood illness and improve maternal and child health/development.
2. Control communicable diseases with an aim of reducing them to a non-public health problem.
3. Prevent, control and manage non-communicable diseases.
4. Strengthen cross cutting health programmes.
5. Enhance efficiency, equity and quality of service delivery through health systems development.
6. Improve effectiveness of governance of the health system.
7. Introduce a health-financing scheme that protects people from catastrophic expenditures and ensures sustainability of the system.
8. Strengthen sector planning and monitoring capability.

Considering the burden of disease in Eritrea and the need to enhance cost-effectiveness of interventions, a Basic Health Care Package (BHCP) that aims at maximising value for available resources by allocating them to interventions that realise the greatest benefits in improving the health of the population has been defined, which shall be the policy framework for future interventions.

The BHCP consist of three priority programmes: (i) maternal and child health, (ii) control of communicable diseases and (iii) prevention, control and management of non-communicable diseases. These programmes are complemented by cross-cutting programme interventions: (i) environmental health services, (ii) health education and promotion, (iii) integrated disease surveillance & response and (iv) disaster preparedness and response.

Efficiency, effectiveness and quality in provision of the BHCP shall be ensured through a continuous improvement of the following essential health systems: (i) human resource for health development and

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management, (ii) medical supplies and management; (iii) health care financing and financial management; (iv) organisation of health services; (v) infrastructure, medical and transport equipment management; (vi) laboratory and diagnostics services management; (vii) health and operational research, (viii) sector planning/ budgeting, monitoring and evaluation.

The priority programmes provided comprehensively with the essential health systems constitute the BHCP. The BHCP will form the basis for design of HSSDP and all operational policies and plans to enable gradual integration of all vertically and horizontally provided services. National gender policies will be mainstreamed into the BHCP implementation guides.

BHCP as an implementation framework will be delivered in an environment of the following cardinal principles:

- Promotion of equity in provision of health service delivery;
- Ownership and participation;
- Partnership;
- Empowerment;
- Efficiency;
- Stewardship

The main thrust of this Policy framework will be to strengthen community based health services; gradually restructure facility-based health services in order to make them more responsive to the people closest to their homes especially in the rural areas mainly through upgrading of health centres to community hospitals or downgrading them to health stations which will require the scope of work of health stations to be enlarged to improve their service to the communities; strengthen decentralised health governance structures; improve efficiency and the quality of care provided by hospitals; restructure the existing health financing framework into an acceptable and appropriate financing structure that minimises catastrophic health-care expenditure and impoverishment of care-seeking individuals and strengthen health sector coordination at all levels to enable better participation of all players, whether public or private.

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## Chapter1: INTRODUCTION

As reflected in its Constitution, Macro-Policy and National Development plans, the Government of the State of Eritrea recognises that a healthy population is necessary for the establishment of a dynamic, productive, economic and resilient society. As Eritrea advances into its third decade from its liberation, there is a need to review its progress and determine the next health policy direction, which shall respond to the national aspiration.

After independence, the government of the State of Eritrea, has focused on the following health priorities:

- ↻ Development of required health professionals to enable provision of basic health services especially primary health care, which was the first key task of the sector.
- ↻ Construction and rehabilitation of health facilities to address the question of equitable distribution of health facilities and improve the quality of services ;
- ↻ Equipping, furnishing and staffing the newly constructed and rehabilitated health facilities
- ↻ Development of a strong health system with special focus on human resources development, governance, HMIS, research, health financing, ensuring the availability of essential medicines and medical supplies and quality improvement at all levels.

### 1. BACKGROUND

#### History

Eritrea was under Italian occupation from 1889 to 1941, the British from 1941 to 1952 and Ethiopia from 1952 to April 1991. In May 1991 the Eritrean People's Liberation Front liberated the country and established a provisional government of Eritrea. A national referendum was conducted under the auspices of the UN and based on the result; Eritrea was declared an independent and sovereign nation on May 24th 1993.

#### Geography

Eritrea is located in the Horn of Africa, between latitudes 12 degrees 42'N and 18 degrees 2'N and longitudes 36 degrees 30'E to 43 degrees 20'E. It is bordered by the Sudan to the north and west, the Red Sea to the east, Ethiopia to the south and the Republic of Djibouti to the southeast. The country has a surface area of about 124,000 square kilometres with four distinct topographic regions: central highlands (2000 meters above sea level), western lowlands (1000 meters above sea level), eastern lowlands (500 meters above sea level) and coastal lands (0-500 meters above sea level).

Administratively the country is divided into six administrative zones known as zobas (Gash Barka (GB), Anseba, Debub, Debubawi Keyih Bahri (DKB), Maakel (Ma) and Semenawi Keyih Bahri (SKB)) zones, 57 sub-zones, 699 administrative areas and 2,564 villages.

Although no population census has been conducted in Eritrea, based on a population estimate by the Ministry of Local Government (2005), the estimated total population of Eritrea is 3.46 million (MOH: Activity Report 2007).

### 2. SITUATIONAL ANALYSIS

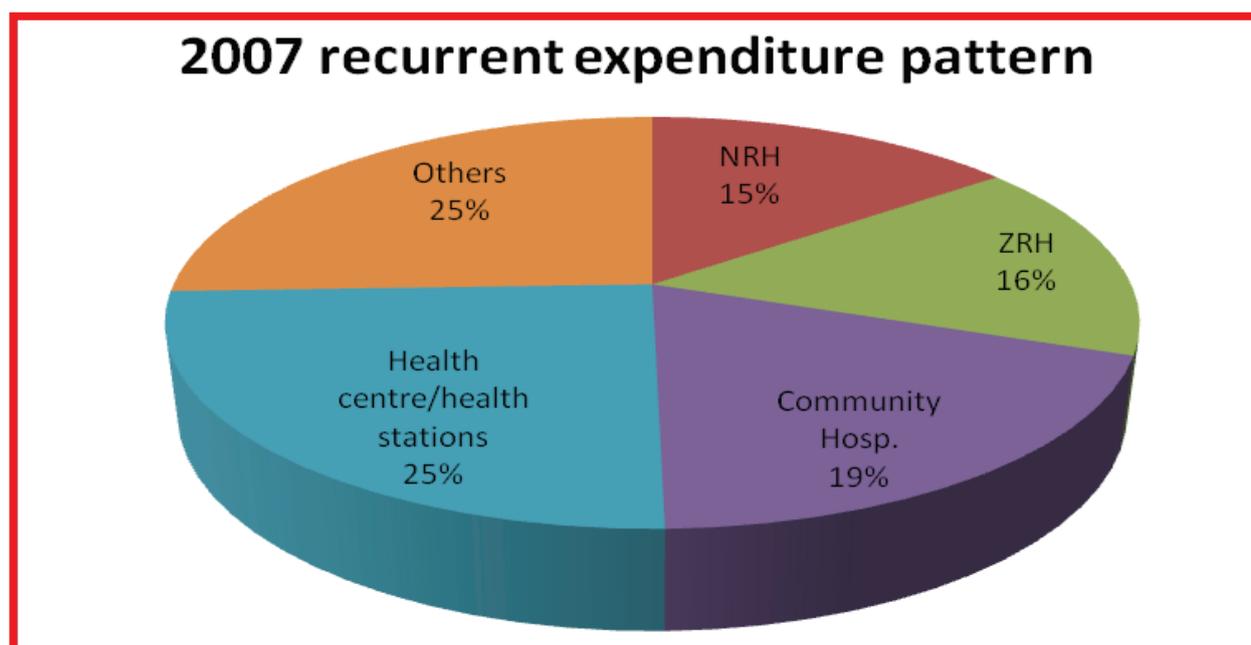
The Eritrean Government at independence inherited a devastated infrastructure; an inefficient agriculture, manufacturing and service enterprises; crippled export sector; and weak public institutions. As a result of

implementation of a post-independence Macro Economic Policy Framework, the economy registered an annual average GDP growth of about 7% over the period 1993-97 and a remarkable improvement in access to education, health facilities and rural roads and other development infrastructure. The border conflict with Ethiopia during 1998-2000 however, hampered the speed of the progress.

The Government of Eritrea has been carrying most of the health care expenditure, with only less than 20 percent cost recovery from users fee. A nominal user's fee scheme was introduced in 1996 taking into account the low socio economic development, the need to improve health care utilization, ruined infrastructure and shortage of skilled humanpower. It was designed in a sliding scale with the nominal fee paid at the primary care levels and higher at secondary level of care and tertiary level. Emergency services are provided free of charge for the first 24 hours in all health facilities whilst primary health care services (i.e. ANC, immunization etc) and selected chronic diseases are exempt. Eligibility for exemption on poverty is on the basis the provision of poverty certificate from the local government with the understanding that the local administration that issues the poverty certificate will be responsible for paying for the services provided to the poor.

Public hospitals absorb approximately 50% of public recurrent budget whilst health centres and health stations absorb approximately 25% (see figure 2 below).

FIGURE 1: FACILITY EXPENDITURE AS A PROPORTION OF THE TOTAL



## 2.1. DEMOGRAPHIC PROFILE

The findings of Eritrea Demographic and Health Surveys (EDHS) in 1995 and 2002 revealed impressive improvement in health status amongst them:

- (i) Life expectancy has progressively increased from 49 in 1990 to 60 in 2000 and 63 by 2007, higher than the Sub-Saharan African average of 51, 50, and 51 during the same years (WHO World Statistics 2009);
- (ii) Infant mortality rate decreased from 72 deaths per 1,000 live births in 1995 to 48 in 2002, which is lower than the Sub-Saharan Africa average of 105;
- (iii) Under-five mortality rate dropped from 136 deaths per 1,000 live births in 1995 to 93 in 2002 which compares favourably with the Sub-Saharan African average of 151; and,
- (iv) Total fertility rate (TFR) had decreased from 6.1 in 1995 to 4.8 in 2002, which is below the Sub-Saharan African average of 5.4.
- (v) Infant Mortality Rate (IMR) and Under-five Mortality Rate (U5MR) were at the same level of the Sub-Saharan average before 1985 but the State of Eritrea subsequently succeeded to reduce

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its child mortality at a much faster pace than the Sub-Saharan average currently recorded as being on track with regard to attainment of MDGs child targets amongst 4 other countries in the region (Human Development Report 2005-geography of child mortality).

## 2.2. EPIDEMIOLOGICAL PROFILE

The leading ten causes of outpatient and inpatient morbidity in Eritrea in the last decade were acute respiratory infections, diarrhoea, anaemia and other nutrition related health problems; skin and eye infections and malaria. Non communicable diseases such as hypertension and other cardiovascular diseases; diabetes, mental health problems, and injuries are also emerging health problems in Eritrea. As a result, the country's health system is tackling a double burden which will affect its strategic direction in the next decade.

According to the routine ANC sentinel surveillance and other data pertaining HIV-AIDS in Eritrea, the national average prevalence of HIV infection among adults stands at around 0.7 percent.

Since 1999 Eritrea has witnessed around 90 percent reduction of malaria morbidity and 80 percent reduction in malaria mortality. The trend over the last decade clearly demonstrates these achievements which have been realised as a result of strategic interventions that included high ITN coverage, early diagnosis, introduction of combination drug therapy, timely management, high level of community awareness and effective participation in vector control and other interventions, and, strong government stewardship.

## 2.3. HEALTH SERVICES

Antenatal care, delivery, immunization, family planning, nutrition and other services are some of the health interventions provided with regard to maternal and child health care. Moreover, the Ministry has undertaken different initiatives such as safe motherhood and IMCI, establishing waiting homes for women at term, empowering women and community to eliminate FGM practice, VCT/ PMTCT in HIV/AIDS control and prevention as strategies to further improve the health status of women and children.

Immunization coverage for all antigens and the number of children immunised before their first year of birth has progressively increased in the last decade from around 10 percent in 1991 to around 90 percent at the moment. The antenatal service coverage (at least one visit) at national level in 2005 was 71%. However, , the proportion of assisted delivery by health professionals is still low at about one third and less than 36% of deliveries received skilled postnatal care.

Finally, it should be noted that the services provided in the referral hospitals in Eritrea have introduced services that go beyond ordinary illnesses that include highly specialized care in Intensive Care Unit (ICU) with sophisticated life support and life saving equipments, neonatal specialized ICU care; highly specialized surgical and medical interventions such as paediatric cardiac surgery and surgery for various congenital abnormalities for children and dialysis for acute cases of renal failure, highly sophisticated and automated laboratory services, imaging services including MRI and CT scan, etc. However, all these state of the art medical technologies and interventions need to be sustained, strengthened and expanded further.

## 2.4. HEALTH INFRASTRUCTURE

The number of health facilities has progressively increased since independence not

only in numbers but also in rehabilitation of dilapidated facilities. This is a product of the Government's commitment to the health of the population and extensive participation of communities and local leaders. The current number of health facilities in the country is shown in the annex

## 2.5. HUMAN RESOURCE FOR HEALTH

The MOH has strengthened its training capacity by increasing its existing institutions and restructuring them to be more responsive and productive. Four Satellite Associate Nursing Schools were opened between 2003 and 2007 in four Zobas.

The MOH has further expanded its educational institutions by opening a new School of Medicine in 2004, and then School of Dentistry in 2007 and taking under its responsibility the College of Health Sciences.

Currently, there are on-going degree programs in medicine, dentistry, nursing, pharmacy, public health and clinical laboratory sciences. Furthermore, a post-graduate medical education program was established in 2007, which is training specialization program in surgery, paediatrics and Gynaecology and Obstetrics and shall soon begin specialization program in other fields including internal Medicine

Short courses are also provided to complement the medical education programme through in-service or on the job training programmes including online distance education, to improve competency and motivation of health professionals.

## 3. CURRENT CHALLENGES

*Maternal and child health:* As previously mentioned, although more than 70% of pregnant women attend antenatal care (ANC), only about one third are delivered by skilled professional attendants. Maternal mortality ratio (MMR) is still high.

Eritrea is one of four countries in Sub-Saharan Africa which are on track towards attainment of health-related MDGs especially with regard to infant and under-five mortality rates and maternal mortality ratio. However, there remains the greater need to reduce neonatal mortality which currently accounts for around half of infant mortality and around a quarter of under-five mortality.

*Control of communicable diseases:* Eritrea has witnessed commendable achievements resulting in an impressive decline of HIV infection.

TB control is still a challenge that requires expansion of existing interventions with a special emphasis on DOTs Strategy in order to improve the overall coverage.

Despite the commendable achievement in the control and prevention of malaria, the threat of resurgence due to climatic changes, cross border transmission and partly due to the national strategy on irrigation expansion for food security, remains a real threat in the foreseeable future. Hence, the remarkable success achieved in preventing and controlling malaria with a reduction of 90 percent in malaria morbidity and 80 reduction in mortality, since 1999 should not lead to complacency.

Furthermore, although there has been good progress in the reduction of the incidence, prevalence and case fatality rate of acute respiratory tract infections and diarrhoeal diseases, they remain to be diseases of public health concern.

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*Non-communicable diseases:* Although non-communicable diseases were historically viewed as a burden of the industrialised nations, evidence shows that this trend is expected to dramatically change globally over the next decade. Epidemiologists estimate that by the year 2020, chronic diseases will account for “seven out of ten deaths in low-income regions of the world compared with less than half today”. This trend is already evident in Eritrea as the prevalence of non-communicable diseases and injuries is increasing. The increasing trend of non-communicable diseases superadded with the prevailing disease burden of communicable diseases, poses a double disease burden challenge.

*Human Resource for Health:* The rapid expansion of the health infrastructure since liberation to cater for national health needs led to a high demand for health personnel. The adoption of primary health care as a policy priority was effectively implemented with the necessary re-orientation of health workers including re-training of staff to standardise the skills of different categories of health cadres that existed. Newer reform initiatives such as decentralisation to the zobas have also introduced new health resource requirements and further challenges for the sector. With the increase of non-communicable diseases together with the burden of communicable diseases, the sector is faced with the challenge of providing specialised services that require a higher level of skilled staff. In essence, the current issue is not only numbers but also competency and the right mix of the health professionals that are able to respond to current, emerging or re-emerging health conditions in Eritrea.

Human resource planning therefore, shall be more responsive to the prevailing health needs and burden, quantity/quality of available resources, technological developments, and other national, regional and international developments. HRH planning also shall consider the staffing pattern at all levels, expansion and restructuring of health care delivery system, attrition and other (such as decentralisation) policies of the government.

*Health Care Financing:* Considering the desire to improve the quality of care in health facilities for a population with an increasing burden of non-communicable diseases, there is need to transform the financing framework that has been in existence from the liberation of Eritrea with the aim of reducing the economic risks borne by individuals and households and concurrently generating other resources for the attainment of the sectors’ strategic objectives.

#### 4. Methodology

This Policy has been developed as a product of collective efforts of key departments of the MOH under the leadership of the Minister of Health. Several programme specific strategic plans and guidelines were referenced as well as relevant international documents. A consensus workshop by MOH management was held 11th – 12th March 2009 followed by further review of subsequent drafts by key MOH management officials.

#### 5. Structure of the policy document

The Policy document provides a summarised description of key current challenges based on the situational analysis that formed the basis for the strategic direction. Building on the general strategic direction, the Policy describes the specific basic health care package strategic direction, the organisation of health delivery system in which the Basic Health Care Package (BHCP) will be implemented. Sector governance, appropriate health care financing and management to support implementation of BHCP are described in later chapters which conclude with the strategic direction for overall sector planning and monitoring.

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## II. GENERAL POLICY DIRECTION

The health sector will endeavour to respond to the Eritrean vision which is *“to become a nation that is economically, politically, socially, , culturally and psychologically well developed”*

### *VISION*

Improved health status, well being, productivity and quality of life of the Eritrean people with an enabling and empowering environment for the provision of sustainable quality health care that is effective, efficient, acceptable, affordable and accessible to all citizens.

### *MISSION*

To promote and provide high quality promotive, preventive, curative and rehabilitative health care services to the Eritrean people

### *MOTTO*

“Healthier Eritreans”

### STRATEGIC OBJECTIVES

- I. Significantly reduce the burden of early childhood illnesses and improve maternal and child health development;
- II. Control communicable diseases with the aim of reducing them to a non-public health problem;
- III. Prevent, control and manage non-communicable diseases;
- IV. Develop and strengthen environmental health, personal hygiene and sanitation;
- V. Strengthen Health education (IEC) and health promotion to enhance health awareness, discourage harmful practices and promote healthy life style;
- VI. Strengthen and periodically review health information management system;
- VII. Establish a mechanism for disaster preparedness and response;
- VIII. Improve effectiveness of governance of the health system.
- IX. Establish effective and efficient health management systems;
- X. strengthen and promote applied health research on major health problems;
- XI. Strengthen inter-sectoral collaboration with all relevant government and non-government bodies to implement multi-sectoral components of the national health strategies;
- XII. Promote and strengthen cooperation with all neighboring countries, the countries of the region, and international organizations;
- XIII. Introduce a health-financing scheme that protects people from catastrophic expenditures and ensures sustainability of the system.
- XIV. Strengthen sector planning and monitoring capability

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## BASIC HEALTH CARE PACKAGE (BHCP)

Considering the burden of disease in Eritrea and the need to enhance cost-effectiveness of interventions, the Ministry of Health has defined a Basic Health Care Package (BHCP) that aims at maximising value for available resources by allocating them to interventions that realise the greatest benefits in improving the health of the population.

presented in figure 2, the BHCP consist of three priority interventions (i) Maternal and child health and Nutrition, (ii) Prevention, control and management of communicable diseases and (iii) Prevention, control and management of non-communicable diseases. These interventions are complemented by the following cross-cutting interventions:

- (i) Environmental Health Services;
- (ii) Health Education and Promotion;
- (iii) Quality of Care,
- (iv) Support Supervision,
- (v) Rehabilitative Health Care
- (vi) Integrated Disease Surveillance & Response;
- (vii) Disaster Emergency Preparedness and Response. Occupational Health
- (viii) Occupational Health

Efficiency and effectiveness in provision of the BHCP is ensured through continuous improvement of the following essential and support health systems:-

- (i) Human Resource for Health Development and Management
- (ii) Pharmaceuticals Procurement, Supply and Logistics Management
- (iii) National Medicines Administration/ Regulation
- (iv) Procurement and Supplies Management System
- (v) Transportation and communication service
- (vi) Medical equipments engineering
- (vii) Infrastructure engineering
- (viii) Laboratory and diagnostic services
- (ix) Medical imaging services
- (x) Blood transfusion services
- (xi) Legal affairs
- (xii) Operational health research
- (xiii) Health Management Information System
- (xiv) Organisation of health services delivery and referral network
- (xv) Hospital and emergency medical care
- (xvi) Integrated essential medical care
- (xvii) Sector planning/budgeting, monitoring and evaluation,
- (xviii) Health financing

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Concurrent implementation of priority and cross cutting health interventions together with essential and support health systems constitute the BHCP. The BHCP will form the basis for the design of health sector strategic development programme (HSSDP) and all other policies, strategic and operational plans to enable gradual vertical and horizontal integration of the existing more vertical projects and programs.

## GUIDING PRINCIPLES

The principles that will guide health service provision in Eritrea in accordance with the Constitution of Eritrea are as follows:

*Promote equity in provision of health service:* this refers to distribution of costs and benefits of health services to all people, regardless of their location, ethnicity, gender, age, social, economic, cultural and political status.

*Ownership & participation:* Under decentralisation, the aim is to enhance client-oriented services that improve the general satisfaction of the people regardless of their social status. This will be achieved by facilitating higher levels of participation in identification of health problems, prioritisation, planning, monitoring, and budgeting decisions. Participation and decision-making in prioritisation, planning, budgeting, implementation progress reviews by the zobas and sub-zobas will therefore, be fundamental to enhancing community ownership and partnership with a special emphasis on women's groups.

*Partnership:* The partnership principle will be facilitated through inter-sectoral collaboration at community, sub-zoba and zoba levels on the one hand, and involvement of the wide spectrum of opinion/influence leaders on the other hand. This entails partnership with other government departments, development partners, traditional healers, etc.

*Empowerment:* The household is the most crucial and effective unit for production of health. Individuals in households with adequate knowledge about prevention of illnesses are able to take timely corrective measures and maintain a healthy lifestyle. It therefore, follows that empowering the individual and households by reaching them through varied social groupings would improve people's lifestyles which in turn would improve the individuals' overall health status. Empowerment will be through a participatory approach in development and implementation of culturally acceptable and scientifically sound health promotion activities.

*Efficiency:* This will involve rationalisation of health inputs to ensure maximum health outputs and outcomes.

*Stewardship:* the MOH will provide leadership through development and provision of policies, strategies, guidelines and technical support to facility and Zoba governance structures. MOH will provide oversight for service delivery and regulate health services provided by the private sector with a special emphasis on vulnerable groups and enhancing access to quality health services.

### III. BHCP-PRIORITY INTERVENTIONS

#### 1. MATERNAL AND CHILD HEALTH AND NUTRITION

##### Maternal Health

The MOH shall strive to strengthen the health system to provide integrated quality reproductive health information and services for a healthy pregnancy and childbearing outcome, healthy sexual relationship, and prevent/cure reproductive diseases.

##### Strategic direction on sexual and reproductive health:

- Provision of evidence-based essential care during pregnancy and all components of sexual and reproductive health;
- Fostering of partnership and advocacy for increased commitment, resource mobilisation for sexual and reproductive health and adoption of a multi-sectoral approach;

##### Child health

Child health will focus on reduction of morbidity and mortality of neonates, infants and children under-five by addressing the main problem diseases such as acute respiratory infection, malaria, diarrhoea, vaccine preventable diseases, and malnutrition.

##### Strategic direction for infant and child health:

- Improving the quality of care provided to children under-five years of age at health facility and household levels using Integrated Management of Neonatal and Childhood Illnesses (IMNCI) strategy and other child survival strategies including interventions targeting the health of the new born.
- Implement strategies to improve and sustain maximum immunisation coverage;

##### Adolescent Health

Adolescent health will focus on the health and safety facing adolescents and young adults including reproductive health, substance abuse including tobacco use, and the prevention of communicable and non-communicable disease.

##### Strategic direction for infant and child health:

- Elevate national focus on the health safety and well being of adolescents and young adults in schools;
- Promote user friendly approaches in the provision of health services, and health and healthy life-styles information targeting adolescents and youth;
- Foster cooperation among different partners concerned with the youth such as the Ministry of Education, the youth and women associations.

##### Nutrition

The nutritional status (including balanced, under and over nutrition) of the population especially amongst children, pregnant and lactating mothers shall be monitored and improved and the prevalence of protein energy and micronutrient deficiencies shall be reduced using various nutrition interventions and nutrition and growth promotion activities

##### Strategic direction on improving nutritional status of the people:

- Promote breast feeding and growth monitoring activities, and strengthen routine supplementation with vitamin A, iron, zinc, etc including during ANC and postnatal care of mothers.

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## 2. CONTROL OF COMMUNICABLE DISEASES

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### HIV/AIDS

HIV/AIDS prevention, control and management activities aim at a significant reduction of incidence and transmission, and strengthening care and support of affected persons.

#### Strategic direction of national response to the HIV/AIDS epidemic and STIs:

- Prevent new HIV infection through targeted interventions;
- Reduce personal and social impact of HIV infection and AIDS including protection of the rights of People Living with HIV/AIDS (PLHAs);
- Strengthen national and international efforts for a sustained and comprehensive multi-sectoral response to HIV/AIDS.

### TB Control

Efforts will be made to significantly reduce the incidence of TB and establish mechanisms for MDR surveillance and management.

#### Strategic direction on TB control:

- Reduce the incidence and prevalence of TB to a level where it is no longer a public health problem using evidence based interventions including MDR surveillance and early management;

### Control of diarrheal diseases and acute respiratory infections

There is a continuing need for strengthening national capacity at all levels to prevent and effectively control diarrheal diseases and acute respiratory infections. In controlling these diseases emphasis shall be placed on integration of interventions for IMNCI, environmental health and community based health activities.

#### Strategic direction for control of diarrheal diseases & acute respiratory infections:

- Surveillance, epidemic preparedness and response
- Prompt and appropriate case management
- Community education and mobilization
- Collaborate with all concerned partners to scale up the use of smokeless oven;
- Promote adequate water supply, sanitation and personal hygiene

### Malaria and other vector borne diseases

Integrated and comprehensive vector-borne disease including malaria control and prevention measures will be strengthened to ensure that malaria will no longer be a public health problem in the country and that the threat of emergence or re-emergence of other vector borne diseases is minimised. These efforts will mainly rely on past positive experience with a special focus on systematic integrated surveillance and vector control.

#### Strategic direction for other control of malaria and other vector borne diseases:

- Early diagnosis, prompt treatment and appropriate management of all vector-borne diseases including malaria;
- Prevention and control of vector borne diseases including malaria through epidemic forecasting;

### Diseases targeted for elimination/eradication

Diseases targeted for elimination / eradication include poliomyelitis (Eritrea is already certified as polio free but shall continue preventing importation), guinea worm (There was no case of guinea worm in Eritrea -since 1960 but needs to continue processing the guinea worm free certification), measles, neonatal tetanus, trachoma and leprosy.

#### Strategic direction on diseases targeted for eradication:

- Pursue certification for diseases targeted for eradication;
- Systematic contact surveillance for new leprosy cases and social mobilisation/management of schistosomiasis;

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### 3. PREVENTION AND MANAGEMENT OF NON-COMMUNICABLE DISEASES AND INJURIES

The emerging non-communicable diseases (NCDs) in Eritrea consist mainly of cardiovascular diseases, diabetes, mental disorders, chronic pulmonary diseases, injuries and disabilities, blindness, deafness, oro-dental diseases and cancers.

Primary prevention through community based interventions emphasising promotion of positive behavioural change of individuals will be conducted using an integrated approach to promote a healthy life style and decrease risk factors using the integrated health promotion strategy approach.

#### Strategic direction for prevention and control of NCDs:

- Promote multi-disciplinary, multi-sectoral and public/private mix preventive interventions at community level that emphasise positive behaviour change;
- Institute measures to reduce NCD risk factors and promote health seeking behaviour through BCC;
- Introduce an NCD minimum package for early case detection and management at all levels.
- Equip health facilities and particularly referral hospitals with skilled human resource, management guidelines and protocols, medical equipments as well drugs and medical supplies for diagnosing and managing non-communicable diseases.

### 4. BHCP- CROSS CUTTING HEALTH PROGRAMMES

#### Environmental Health and Sanitation

Environmental health service will aim to contribute to the reduction of morbidity, mortality and disability among the people of Eritrea through improvement in people's habitation, workplaces, food and water intended for consumption as well as reduction of environmental risks to health.

#### Strategic direction to strengthen environmental health services:

- Promote maintenance of health standards of sanitation, personal hygiene, housing, workplaces, drinking water, food, waste management and control of vectors/vermin;

#### Health Promotion

Health promotion plays pivotal role in prompting health and healthy style of life to prevent and control the double burden of both communicable and non communicable diseases as well as the maternal and reproductive health problems that Eritrea is facing at the moment. The general objective of health promotion is establish and sustain a multi-sectoral, society-wide and community-based framework that will guide the development and implementation of integrated interventions for improving the health of people of Eritrea.

Health Promotion shall be seen as the process of enabling/empowering people to increase control over decisions and actions that affect their health. Patients, Individuals and Communities shall also be seen as co producers for the outcome and impact of all health interventions. As the co-producers, in order to get involved and actively contribute to the process, they have to be actively empowered for making the contribution.

#### Strategic direction to strengthen health promotion:

- Information, education and counselling (IEC) shall be given prominence to enhance health awareness, discourage harmful practices and promote healthy life style;
- Ensuring BHCP health messages targeting the community in order to meet the set health objectives.

#### Quality of Care

The quality of care and infection prevention is an important component of health care delivery, and shall ensure good quality health services given available inputs for maximum outputs and

efficient utilization of resources.

Strategic direction to strengthen quality of care include:-

- Facilitate establishment of internal quality assurance capacity at all levels of health services; Enhance awareness and understanding among the health workers of the importance of quality health services.

Support Supervision

Supervision, Monitoring and Mentoring is an essential aspect of health system, and important in determining quality of health services and the efficiency of the system. The main aim of support supervision is to provide regular and appropriate supervision of the different entities of the health sector as a means to ensuring efficient and equitable delivery of good quality health services and to develop and disseminate key support supervision guidelines.

Strategic direction to strengthen support supervision include:-

- Supervision and Monitoring to and Zoba branch offices.
- Supervision and Monitoring of health facilities by technical health workers
- Supervision of central programs within MoH and other central institutions;

Rehabilitative health care

This element of health care encompasses conditions that result in deprivation or loss of the needed competency. This may be due to damage or harm done to or suffered by a person before or after birth. The conditions include physical disability, deafness, blindness, and learning disability.

Strategic direction to strengthen rehabilitative health care include:-

- Put in place preventive, promotive and rehabilitative interventions to reduce mortality morbidity or disability caused by injuries
- In collaboration with the Ministry of Labour and Human welfare, undertake Community Based Rehabilitation (CBR) and intensive mobilization of communities for early detection and proper treatment of disorders of sight, hearing, mental disorders and other disabilities in order to minimize complications.

Integrated Disease Surveillance & Response (IDSR)

Prevention and control of communicable and non-communicable diseases will be realised through strengthening of integrated surveillance and response by building on the existing experience.

Strategic direction to strengthen IDSR

- Strengthen preparedness planning and surveillance capabilities at all levels including border points, environmental health risk areas and notification of events in compliance with (International Health Regulations) IHR;
- Regularly review strategies and IDSR tools.

Disaster preparedness and response

Eritrea like most countries in the region is not impervious to disasters that have been witnessed globally such as storms, floods and droughts which are further worsened by complex humanitarian emergencies arising from a combination of factors including war or civil strife, food shortages and population displacement that have become common within the sub-Saharan region. Health

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response to disaster risk reduction will be main-streamed into the national strategy recognising that health is a unifying force for action during disasters.

**Strategic direction to strengthen disaster preparedness & response:**

- Strengthen preparedness planning surveillance and response capabilities;
- Develop a level of resilience that strengthens the capacity of health facilities and management systems to remain functional in emergency and disaster situations.

### Occupational health

Due to the current and anticipated increments in industrial, agricultural, mining, port etc. development activities in Eritrea, there is need to scale up interventions in Occupational Health. There is also need of promoting Occupational Health services and practices in workplaces with special emphasis on the high risk sectors. The main aim of occupational health is to establish a system of provision of Occupational Health services, both for the public, private and the informal sector.

**Strategic direction to strengthen support supervision include:-**

- Delivery of occupational health services by all health facilities
- Awareness building for occupational health services by workers, employers and the confederation of Eritrean workers.

## IV. BHCP ESSENTIAL SYSTEMS

### 1. HUMAN RESOURCE FOR HEALTH

In response to encountered health challenges, the health sector adopts the following policies and strategies for human resource planning, development/training, continuing education and management of human resource for health in Eritrea.

#### Human resource planning

Human Resource Development will ensure availability of human resources with the right qualifications, skills and attitudes at the right time, in the right mix to deliver good quality of health services at all levels.

**Strategic direction to enhance (Human Resources for Health (HRH) planning:**

- A national HRH database of all health professionals will be maintained and continuously updated;
- Staffing norms/standards based on BHCP will be developed and periodically updated.

#### Human resource development (HRD)

Competent health professionals whose qualifications are in accordance with the health needs of the population will be trained, recruited and retrained. The MOH in active collaboration with the training institutions shall be responsible for the designing and development of curricula for all training programmes related to health in order to ensure their relevance and excellence. Furthermore, it shall be part of the decision making in the establishment, revision or the phasing out of any training programme related to health.

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#### Strategic direction to improve HRH:

- The MOH shall strive to ensure quality of teaching and expansion of training institutions;
- Special consideration will be made for the under-served regions and ethnic groups and an enabling environment will be created to encourage their involvement;
- Create an ensuring environment which encourages females involvement at all levels of training.
- In-service training including specialised development/training shall focus on a comprehensive BHCP based service delivery with an emphasis on PHC principles and guidelines and staff will have equal opportunities for training;

#### Human resource management

Human resource management shall aim at efficient and effective recruitment, distribution and retention of appropriately skilled and motivated health workers to ensure the provision of good quality health services at all levels.

#### Strategic direction to improve HRH management:

- Staff recruited by the health services shall be based on vacancies in the approved establishment and distributed based on workload, equity and geographical areas ;
- Job description, transfer, promotion and deployment policies shall be developed.
- Performance appraisal will be established to support performance management of BHCP.
- Developing career structure, remuneration and incentives for all categories of health workers.

## 2. MEDICINES AND MEDICAL SUPPLIES

Priority will be given to ensure availability and accessibility of safe, effective and good quality essential medicines to all with a special emphasis on the under-served areas and promotion of rational medicines use. The National Medicines Policy (NMP) is the framework to coordinate activities in the pharmaceutical sub-sector.

#### Strategic direction to improve availability, access and rational use of medicines/medical supplies:

- Strengthen regulatory mechanism to maintain standards of manufactured, imported, exported, marketed and locally utilised medicines/medical supplies through medicines registration, licensing of pharmaceutical premises and pharmacy practitioners, inspection and control;
- Develop quality control capability to assure efficacy and safety of medical supplies;
- Use national list of essential medicines as a guideline;
- Promote rational use of medicines by prescribers, dispensers, patients and community through provision of necessary measures including training, education and information;
- Promote and support local production of essential medicines/medical supplies and investment in manufacturing, importation and distribution of medicines/medical supplies;
- Strengthen a logistics management system for all supplies including laboratory and other diagnostic services;
- Identify and document traditional medicines and practices in use and promote their safety and efficacy;
- Develop a legal framework, policy and code of ethics to guide traditional medicine practice.

## 3. INFRASTRUCTURE, MEDICAL AND TRANSPORT EQUIPMENT

Building on the almost two decades investment on health infrastructure and equipment, the next phase of development shall be to consolidate previous gains as well as to continue constructing new health facilities and introducing new medical technologies and advancements to fill the identified gaps in provision of service and referral network, aimed at the attainment of NHP goals.

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**Strategic direction to improve infrastructure, medical and transport equipment:**

- Facilities will have a supply of BHCP-based standardised equipment drawing from an essential health equipment list that will be developed and regularly reviewed.
- Strengthen planned preventive maintenance (PPM) and rehabilitation where necessary, especially at zonal and sub-zonal levels including allocation of a proportion of the non-wage recurrent budget for PPM;
- Ensure BHCP based transport needs to enable smooth functioning of the health care system.
- Renovate or construct new health facilities where necessary in order to promote equity through reaching the unreached as well as to in order to further strengthen the quality of the provision of health care and referral network.

#### 4. HEALTH LABORATORY AND DIAGNOSTIC IMAGING SERVICES

Laboratory services provide cross cutting clinical and public interventions for the purposes of prevention, treatment and surveillance at all levels. The health laboratory also functions as the quality control for food and beverages in collaboration with other laboratories..

Similarly, the imaging and other diagnostic services will be strengthened by improving their coordination mechanism through development of a comprehensive BHCP needs-based plan and strengthening their national and zonal management capacities.

**Strategic direction to improve the national health laboratory**

- Establishment of a coordinated, integrated and standardized national quality control, quality assurance and supportive supervision network system of the laboratory units in all health facilities;
- Development of laboratory information system and monitoring and evaluation;
- Development of relevant guidelines, standard operating procedures and training and equipment maintenance manuals;

**Strategic direction to improve imaging and other diagnostic services:**

- Development of a strategic plan for imaging and other diagnostic services that include strategies for strengthening of a coordinated network with defined roles and responsibilities and projection of skills and equipment requirements;
- Strengthening of quality management system for all diagnostic services including standardized equipment, infection control, radiation and other safety systems.

#### 5. HEALTH MANAGEMENT INFORMATION SYSTEM

Ministry of Health will require improved data management system at all levels for effective monitoring and evidence based decisions and research. Emphasis will be on quality of collection, storage, analysis and dissemination of health information at all levels, building on past experience and assessments of the HMIS system to progressively integrate all BHCP information and create an integrated and automated information hub or repository at central and zonal levels.

**Strategic direction to strengthen data management:**

- Review and strengthen a central and zonal-based automated health data repository that consolidates health data from all sources for BHCP and creates a platform for sharing and decision-making information;
- Ensure quality of information and timelines of development and dissemination of the Annual Health Services activity report, for timely decisions and corrective actions aimed at improving the quality of health care.

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## 6. HOSPITAL REFORMS

Cognisant of the need to improve the quality of health care provided by hospitals to make them responsive to the needs of the population, the MOH will introduce hospital reforms including some form of hospital autonomy whose aim is to improve the quality of care, cost containment and thereby sustainability of services.

**Strategic direction to introduce hospital reforms:**

- Develop an evidence-based hospital reforms Strategic Plan

## 7. HEALTH RESEARCH

Health research will focus on providing new insights and knowledge to solving health problems and improving health status of the people through evidence-based disease prevention, health promotion and treatment.

**Strategic direction to improve health research:**

- Promote research capability of national institutions to generate new knowledge or application of existing knowledge.
- Expand applied research on major health problems and health service systems development and establish health research resource centre(s);
- Develop and maintain capabilities for operational research at all levels of care to support evidence based BHCP interventions;
- Collaborate with and encourage local and international academic institutions and other health related organisations to conduct research on identified priority health problems and health systems;
- Develop appropriate measures to ensure strict observance of ethical principles in research.

## V. ORGANISATION OF HEALTH DELIVERY SYSTEM VI. AND REFERRAL NETWORK

### 1. STRUCTURE OF HEALTH DELIVERY SYSTEM

The health delivery system in Eritrea is organised in a three-tier system namely primary, secondary and tertiary levels.

#### 1.1 PRIMARY LEVEL SERVICES

##### *Community-based health services (CBHS)*

A community is defined as a catchment area (a Kebabi) with an estimated average population of 500-2000 people. BHCP will be provided at the community level by empowering communities, mobilising and maximising available skills and resources. Community health services will be delivered by appropriately trained and equipped Community Health Workers with an aim of progressively harmonising and integrating the services of the different BHCP programmes under the leadership of the Kebabi Health Committee. In addition, the Ministry will invigorate the community health services to attain better results by taking services of nurses/midwives to the communities through outreach services.

##### *Health station services*

A health station is a primary health facility which provides promotive, preventive, and basic curative services of the BHCP and serves a population of about 5,000-10,000. The health station also supports community based health services by conducting regular support supervision within its

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catchments area training of community health workers and organising outreach services. As part of the re-structuring of the health centre services, health station capacities will be progressively be reviewed with relevant needs-based expansion.

### *Health Centre*

A health centre is a primary health care facility which is currently functionally higher than the health station providing promotive, preventive and basic curative services of the BHCP as per defined guidelines. In addition, a health centre is responsible for supervising the work of the health stations and training of community health workers (CHW) in its catchments area.

Health centres shall progressively be upgraded into community hospitals and where necessary down-graded to health stations to a level that they will no longer exist.

### *Community hospital services*

Hospital services in the sub-zoba, shall be provided by Community Hospitals which forms the apex of the primary level of service serving a population of approximately 50,000 – 100,000 dependent on geographic access and terrain. A community hospital will offer out-patient and in-patient services and will be equipped to perform general surgical and obstetric operations as per BHCP guidelines acting as a referral centre for patients from lower level health facilities of the sub-zoba. They operate under the local authority through a Hospital Management Team.

Community Hospitals will provide services, conduct teaching and training of middle and operational level health professionals; conduct action oriented research programmes; conduct supportive supervision and provide technical support to lower health facilities in the sub-zoba.

## 1.2 SECONDARY LEVEL SERVICES

### *Zoba Referral Hospital (ZRH) services*

The Zoba Referral Hospital is a facility that provides secondary level service as well as serving as the highest referral hospital in the zoba. It operates under the Zoba Medical Office and is mandated to execute the following functions: provide all services offered at sub-zoba level but at a higher level of expertise; serves as a referral centre for primary level facilities in the zoba; conducts teaching and training of middle and operational level health cadres; conducts health research programmes including operational research of health systems in the zoba; provides technical support to lower health facilities in the zoba and offers defined specialised services. More than one hospital that provides secondary level services may be located in a zoba dependent on geographical and other reasons One of these facilities will be designated as the ZRH for administrative reasons and ease of strategic resource allocation..

## 1.3 TERTIARY LEVEL SERVICES

### *National Referral Hospital (NRH) services*

The tertiary level is the highest level of health care comprising of National Hospitals that offer all medical services offered by the zobal referral hospitals but at a higher specialist level . The national referral hospitals will be organised in the most cost-effective manner to ensure maximum synergy of the various health professionals, staffed with the best mix of qualified specialists, and equipped with modern diagnostic medical equipment that enables the country to meet the growing expectations/ demand of the people. This will include development of specific needs-based centres of excellence within the national referral hospitals to cope with the dynamic nature of health care and their establishment as research and training centres for the country. .

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## 2. STRENGTHENING REFERRAL SYSTEM

Referral guidelines that are based on the set norms and standards will be developed regularly, revised and widely disseminated to public and private health professional and facilities at all levels. They will also define acceptable criteria for referral of patients for advanced treatment abroad.

**Strategic direction to improve service delivery and strengthen the referral system:**

- Provide regularly reviewed BHCP-based referral guidelines for all level that ensures a continuum of patient/client care.

## VII. SECTOR GOVERNANCE

### 1. SECTOR COORDINATION

The Ministry of Health will continue to collaborate and build partnership with other Government sectors, development partners, and the private sector in order to ensure smooth implementation of the BHCP. It is only by collaborating and building partnership with all stakeholders that the objectives of this NHP can be realised. Therefore, an appropriate coordinating mechanism that ensures effective coordination of all stakeholders will be put in place. This mechanism will facilitate collaboration through establishment of appropriate inter-sectoral structures at all levels.

To facilitate the process of collaboration the Ministry will work on a common framework for health sector planning, budgeting, disbursement, programme management, support supervision, accounting, reporting, monitoring and evaluation which would meet the requirements of all development partners.

#### *Private Organizations*

Private organisations (both private-for-profit and private-not-for-profit) shall be permitted to actively participate in all aspects of the health system including service delivery and health financing under the regulations issued by the government.

Hospitals may establish a private wing or section that shall work for profit and for widening the scope and choice on the mode of health service delivery, including self referral to a specialist service.

#### *Development Partners*

Development partners shall be encouraged to contribute technical and financial support with an emphasis on untied and predictable aid, while efforts are being made to move towards self-sufficiency and sustainability. Efforts will be made to ensure that all resources including ODA will be aligned to NHP and HSSDP and avoid parallel implementation structures by use of coordinated programmes structures. Mechanisms will be put in place to strengthen national procurement and public financial management systems that either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve the required good practices. Joint partners (Government and Development Partners) will undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness.

**Strategic direction to improve sector coordination:**

- Establish and maintain an appropriate sector coordination mechanism on the basis of NHP principles
- Establish a national Public-Private Partnership (PPP) coordination mechanism through a consultative process, that would enable collaboration in planning, monitoring and regulation;

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## 2. DECENTRALISATION

Decentralisation is recognised by the GoE as a dynamic process of changing relationships between the centre and the periphery, with the local level taking more authority and responsibility. According to the Proclamation, each Regional Administration shall have the following administrative levels: 1. Regional Administration, 2. Sub-Regional Administration, 3. Village/Area Administration.

At the national level the MOH will continue to provide health policy guidelines, standards and regulations for the sector. In order to do so, it will periodically review its structure to enable it to provide adequate stewardship for the attainment of NHP objectives.

Zoba health management will provide leadership and supervise all health services in the zoba, including services provided by ZRH as per the Zoba Health Management Committee (ZHMC) and Health Systems Management Team guidelines that will be regularly reviewed. The Sub-Zoba health management will provide leadership for CBHS, lower level primary health facilities and services as per the Sub-Zoba Health Management Committee and Health Management Team guidelines that will be regularly reviewed.

Technically the Zoba Health Management Team (ZHMT) will be responsible through the Zoba Medical Officer (ZMO) to the Minister of Health and administratively the ZHMT will be responsible to the Zoba administration through the Zoba Health Management Committee (ZHMC). Technically the Sub-Zoba Health Management Team (SZHMT) will be responsible to the ZHMT and administratively to the Sub-Zoba administration. The composition of ZHMC and SZHMT will include local leaders, private sector and multi-sectoral representatives.

Kebabi Health Committees (VHC) shall be established and supported to provide leadership for community based health services under the technical guidance of the SZHMT and administrative guidance of the Kebabi Administrator.

**Strategic direction to strengthen decentralised governance structures:**

- Regularly review and strengthen zobal and sub-zobal sector governance structures performance.

## 3. HEALTH STANDARDS AND REGULATION

In order to ensure that quality of health care delivery is improved and maintained within an organised and seamless continuum of care, BHCP based laws, regulations, norms and standards will be developed and regularly revised for all resources including human, financial, physical infrastructure, equipment, material and services provided at the community to the national levels. Laws and regulations will be reviewed to make them relevant for the attainment of NHP objectives and specifically for the enforcement of set norms and standards where appropriate.

Set norms and standards will form the basis of an accreditation mechanism that will be initiated and maintained for public/private health facilities, health professionals, training institutions, and regulatory services.

**Strategic direction to improve health standards:**

- Develop new legislation such as public health, ethical issues and professional regulations
- Develop and regularly review BHCP-based norms and standards which are linked to service guidelines for each level;
- Regularly review and amend if necessary existing laws to support the enforcement of policy objectives;
- Regularly conduct accreditation of public and private facilities;
- Adopt and implement relevant international health related treaties and conventions to which Eritrea is a part.

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## VIII. HEALTH CARE FINANCE AND MANAGEMENT

The Government will continue to enable provision of quality and equitable services by funding these services and exploring innovative and appropriate financing mechanisms from all sources. This will be done with the key principle of making financing fairer to all people and especially the poor and vulnerable groups ensuring that no one who requires health services will be turned away on account of non-payment.

### 1. FINANCING SOURCES

The Government will continue to be the major financier of health services and necessary efforts will be made to improve the existing financing framework by an incremental re-structuring of the out-of-pocket payments to reduce the burden on households whilst enhancing involvement of the private sector in health financing. This will be realised by adopting a diversified complementary health care financing mechanism guided by the principles of efficiency (macroeconomic and microeconomic efficiency) and equity (horizontal and vertical equity) that ensures all Eritreans are treated according to need and not according to ability to pay.

#### *Zoba Administration and Service Provision*

The Central Government will continue to finance health services in the country. But to ensure sustainability and ownership of health service delivery, Zoba Administrations will be encouraged and supported to generate supplementary funds for the health sector without countering or violating national policies and guidelines and without raising the resources through user-fees as an addition to the MOH set fees.

#### *Community Contributions*

Communities will contribute towards financing of health services using the following modalities:

##### *1. User fee*

Communities will be encouraged to contribute through user-fees in health facilities to complement government financing. Cognisant of the adverse effects of user fee on the overall household income, appropriate measures will be taken to protect those who need health care most, with a special emphasis on the poor and vulnerable social groups. User fee structure will be periodically reviewed so that it would act as a deterrent for the excessive use of services rather than a barrier to access of services. Exemption mechanisms will be strengthened to guarantee access to the poor and vulnerable groups regardless of their ability to pay, with monitoring benchmarks that ensure protection of the target groups.

Private wings or sections in public hospitals for those who are able and willing to pay for services and pharmacies on full cost recovery will be established in phases from the national to community hospitals. Revenue accrued from these Private wings or sections in public hospitals shall form part of the general hospital revenue to enhance quality of services provided and facility improvement.

##### *2. Health Insurance Schemes*

The Government shall develop evidence based mechanisms of risk-sharing and cross subsidisation that facilitate solidarity and equity. This will be achieved through a phased introduction of health insurance scheme(s) that will be informed by actuarial and socio-economic feasibility studies.

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Private health insurance schemes will be encouraged to enable willing individuals to insure themselves for premium services although, they will not be exempted from making contribution to the public health insurance schemes as determined. A regulatory framework will be developed to safeguard the resources and interests of the public who choose to join these schemes.

## 2. BUDGET ALLOCATION

Budget allocations for health sector will be based on equity principles, the Basic Health Care Package, and special needs of vulnerable groups. The details of budgetary allocations will be reflected in the respective guidelines.

## 3. FINANCIAL MANAGEMENT

Funds for central and zoba level activities shall be disbursed based on approved health plans and cash flows. Implementation will be monitored on quarterly basis using the quarterly progress implementation and financial reports.

### Strategic direction to strengthen financial management and health care financing:

- Regularly update financing skills and operating tools for decentralised structures based on Ministry of Finance guidelines;
- Regularly review user fees guidelines to make them relevant to the prevailing socio-economic dynamics;
- Conduct health care finance analytical studies jointly with key sectors;
- Develop evidence-based Health Care Finance Policy and Strategic Plan through a consultative process.

## IX. SECTOR PLANNING, MONITORING AND EVALUATION

Mechanisms will be put in place to enhance sector planning, monitoring and evaluation framework and the use of a transparent and quantifiable performance assessment framework to assess progress against the national development strategies and sector programmes.

### 1. SECTOR PLANNING AND BUDGETING

Zoba health operational planning will be the cornerstone of decentralisation that will be guided by NHP and HSSDP.

### Strategic direction to strengthen health sector planning & budgeting:

- Regularly develop a Health Sector Strategic & Development Plan (HSSDP) every five years to guide sector players;
- Support zobas to develop needs based planning that progressively will lead to a bottom-up community level participatory planning as the capacity improves as per the National Development Planning Framework;
- Establish and maintain a planning and monitoring office at national level to systematically enable development of the sector's planning/budgeting and monitoring capacity.

### 2. SECTOR MONITORING AND EVALUATION

Monitoring and evaluation will be carried out continuously throughout the process of planning and implementation. Scheduled supportive supervision will be conducted and incorporated in the NATIONAL HEALTH POLICY

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operational plans of the different levels to include regular supportive visits by a higher level to the next level using a guideline.

**Strategic direction to strengthen sector M&E:**

- Development and regular revision of an agreed sector set of performance indicators;
- Hold regular operational performance review meetings at all levels of a zoba and annual sector performance reviews;
- Regular supportive supervision will be conducted using a comprehensive standard checklist;
- A sector mid-term review will be carried out 2½ years into implementation of HSSDP with the aim of assessing achieved outputs and outcomes vis-à-vis the set objectives to inform the next stages of roll-out and an end-term evaluation after 4½ years.

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## References

1. The Constitution of Eritrea. Ratified by the Constituent Assembly May 1997.
2. MOH: Draft National Health Policy. 14th September 2004
3. MOH: Draft Health Sector Strategic Development Plan 2010-2014 Ministry of Health.
4. Annual Health Service Activity Report of 2007
5. World Bank: Eritrea Health Sector Note. 30th June 2003
6. MOH: Draft National Health Financing Policy. 2007
7. MOH: Draft National Policy on Gender- A framework. January 2004 Government of the State of Eritrea: Draft Interim Poverty Reduction Strategy Paper (I-PRSP). 2004
8. Government of the State of Eritrea: Eritrea Demographic and Health Survey 2004
9. MOH: Non-Communicable Diseases Policy. May 2008
10. MOH: Eritrean National Medicines Policy. August 2007
11. MOH: Human Resources Development Policies and Strategies. June 2003
12. MOH: Tuberculosis Policy and Guidelines. September 1998
13. MOH: 5-year Strategic Plan on Tuberculosis 2004-2008
14. MOH: Strategic Plan of Action for the control of cardiovascular diseases and diabetes in Eritrea 2008-2012. May 2008
15. MOH: Draft Eritrea National Strategic Plan on HIV/AIDS/STIs (ENASP 2008-2012. January 2009.
16. African Union: Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights. September 2006
17. MOH: Sexual and Reproductive Health Policy. January 2006 (Draft)
18. MOH: Draft National Reproductive Health Strategy for Eritrea 2006-2011. December 2005
19. MOH: Draft Nutrition Policy. November 2007
20. United Nations Development Programme: Human Development Report. 2005
21. MOH: Draft National Health Promotion Policy. February 2007
22. MOH: Zoba Health Management Committee Guidelines
23. MOH: Zoba Health Systems Management Team Guidelines. April 2006
24. MOH: Hospital Management Committee Guidelines. April 2006
25. MOH: Hospital Management Team Guidelines. April 2006
26. MOH: Sub-Zoba Health Management Committee Guidelines. May 2006
27. MOH: Sub-Zoba Health Management Team Guidelines. May 2006
28. MOH: Draft Village Health Committee Guidelines.
29. MOH: Draft Introducing Hospital Autonomy in Eritrea. May 2007
30. MOH: National Technical Guidelines for Integrated Disease Surveillance and Response in Eritrea. September 2001.
31. MOH: Integrated Disease Surveillance and Epidemic Response System in Eritrea 2001-2005.
32. World Health Organisation: Mission Report- Situational assessment of the Laboratory Network in Eritrea. January 26-30th 2009
33. MOH: National Blood Transfusion Policy. August 2006
34. MOH: Eritrean Roll Back Malaria Program- 5 Year Strategic Plan 2005-2009. January 2005

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35. MOH: Health Information System Strategic Plan (HISSP) 2009- 2013
  36. MOH: Conceptual Framework for national integrated Monitoring & Evaluation System 2008-2012. August 2008
  37. MOH: Draft Eritrea Public Expenditure Review, Health Chapter
  38. <http://www.who.int/nha/glossary> (accessed 12th February 2009).
  39. WHO: Libreville Declaration on Health and Environment in Africa. 29th August 2008
  40. WHO: Ministerial Conference in Research for health in the African Region. Algiers, 23-26th June 2008
  41. HNP-World Bank Human Development Network: Organizational Reform in the Hungarian Hospital Sector J.M. Rethelyi et.al. December 2002.
  42. Eurohealth: Implementing hospital reform in central and Eastern Europe and Central Asia. Volume 7 August 2001.
  43. WHO: World Health Report 2000
  44. World Bank-Private Sector and Infrastructure Network: Public Hospitals, Options for reform through public-private partnerships. January 2002
  45. MOH: National Blood Transfusion Policy of Eritrea. August 2006
  46. WHO: Sustainable health financing, universal coverage and social health insurance, (WHA58/2005/REC/1). 2005
  47. WHO: Health Financing: A Strategy for the African Region, AFR/RC56/10. September 2006
  48. United Nations International Strategy for Disaster Reduction: Acting for Common Purpose. June 2007
  49. MOH: Health Research Policy and Policy Guidelines. November 2006
  50. WHO: International Health Regulations, AFR/RC56/Info.Doc/2 July 2006
  51. MND: National Development Planning Framework (1st draft): The way forward. February 2009
  52. MND: Indicative Development Plan 2009-2013(1st draft). February 2009
  53. WHO: World Health Statistics 2009